On Point Nutrition
Accredited Practising Dietitians & Nutritionists
Ph: 0419 676 324
Fax: (07) 3014 0146
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# New Client Registration, Privacy and Consent Form

*On Point Nutrition* is committed to providing our clients with the best possible nutrition care. To do this, it is essential that your health information is accurate and kept up to date. Could you please assist us in this process by completing the following personal and health information:

First Name: _____ Surname: _____

DOB: _____ Medicare / DVA No. _____ Ref: _____

Address: _____Post code: _____

Postal Address: ☐ *(or tick if as above)* _____

Phone: _____ Mobile: _____ Work: _____

Email: _____

Usual GP: _____ Clinic Location: _____

**Privacy and Information Collection Consent**

*On Point Nutrition* needs to collect information about you for the primary purpose of providing a quality service to you. In order to thoroughly assess, diagnose and provide therapy, we need to collect some personal information from you. If you do not provide this information; we may be unable to treat you. This information will also be used for:

- The administrative purpose of running the practice;
- Billing either directly or through an insurer or compensation agency;
- Use within the practice if discussing or passing your case to another practitioner within the practice for your ongoing management;
- Disclosure of information to your doctors, other health professionals or to teachers to facilitate communication and best possible care for you; and
- In the case of insurance or compensation claims it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your employer.

*On Point Nutrition* has a Privacy Policy, which provides guidelines on the collection, use, disclosure and security of your information. This Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint. To ensure quality health care and treatment can be provided, information about your health/nutrition/dietetic assessment, diagnosis, intervention and progress may be given to other relevant service providers, who are involved in your management. These may include your doctor, medical specialists, allied health professionals, teachers and insurers.

I understand and accept that:

- It is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment and therapy progress;
- I can access my personal and treatment information on request and if necessary, correct information that I believe to be inaccurate; and
- If in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.

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**Phone, Video, Email and Text Message Communication Consent**

The risks of communicating by phone, video, email and/or text message (SMS) include but are not limited to:

- Email and text messages can be circulated, forwarded and stored in paper and electronic files;
- Backup copies of email/text may exist even after the sender or recipient has deleted his/her copy;
- Senders can easily misaddress an email/text, or email/text can be received by unintended recipients;
- Emails and texts can be intercepted, altered, forwarded or used without authorisation or detection;
- Employers and online services have a right to archive and inspect emails sent through their systems;
- Emails/texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
- Mobile phone coverage and/or service quality may be limited and/or less reliable during times of peak usage, high demand and/or in regional, rural or remote areas. Video communications rely on internet or Wi-Fi connections, which may also be less reliable or lower quality for the above reasons.
- Please consider providing an alternative contact number or landline phone number if possible, if connecting with your Dietitian via telehealth - phone or video (please add to your personal details on page 1).

I have read, understand and agree to the following terms and conditions:

- I give consent for myself/my child to receive Nutrition/Dietetic services from *On Point Nutrition*.
- I have provided *On Point Nutrition* with fully completed referral documents from my/my child's referring GP (applies only for Chronic Disease Management (CDM), Eating Disorder Management (EDM) plans, DVA referrals).
- If I/my child attends an initial appointment without a fully completed CDM plan, EDM plan or DVA referral, full fees are payable. Full fees are outlined on the *Schedule of Fees* provided or at https://onpointnutrition.com.au/fees/
- My/my child's participation in treatment is voluntary and I can withdraw my consent at any time.
- I have informed *On Point Nutrition* of any previous or existing medical conditions, allergies or other conditions which may impact or affect my child's/my health and Nutrition/Dietetic care.
- I have been provided with/given opportunity to obtain a copy of the *On Point Nutrition* Privacy Policy.
- I consent to communication via phone, video, email and/or text message where practical or required for clinical care and/or administrative purposes, I understand the risks of communicating in these ways and that *On Point Nutrition* cannot guarantee confidentiality of information transferred in these ways.
- I understand that *On Point Nutrition* will take reasonable steps to ensure my privacy and confidentiality throughout all methods of communication and correspondence.
- The *On Point Nutrition* Accredited Practicing Dietitian (APD) will take notes during consultations and will provide feedback via written correspondence to my referring doctor/specialist.
- Where applicable for referrals covered under Medicare or Department of Veterans' Affairs (DVA) to receive bulk billed services, I assign my right to benefits to the APD who provided the service.
- If I do not attend a scheduled appointment, or if I do not provide at least 24 hours' notice to cancel my appointment, the fee payable is the full cost of this appointment. This fee cannot be bulk billed or rebated.

I have read, understand and agree to the above information. I understand that I am not obliged to provide any information, but failure to do so may compromise the quality of my/my child's health care and therapy/treatment able to be provided.

Client Name: _____

Signature: _____ Date: _____

***Parent / Carer / Guardian - Please complete below if the patient is under 18 years of age, or has a Carer:***

Parent / Carer / Guardian Full Name: _____

DOB: _____ Medicare Card No. _____ Ref: _____

Pension or Health Care Card no *(if applicable)* _____